Authorization for Disclosure of Protected Health Information

Guthery Family Practice Clinic LLC

To the following person or class of persons: To any and all physician's health care providers, health care facilities, or healthcare entities that provide or have provided health care services to the patient named below.

Patient name ____________________________ **Date of birth**: ________________________________

Note: "You" refers to the person(s) to whom this authorization is directed. "I", "me" refers to patient

Authorization

You are hereby authorized to disclose my protected health information, whether oral, written or electronic healthcare information pertaining to my complete medical record, including but not limited to HIV and AIDS confidential information. You are hereby authorized to disclose my protected health information specifically pertaining to my mental health, including but not limited to psychiatric and psychological information, drug and alcohol abuse treatment information. You are hereby authorized to disclose my protected health information to any physician health care provider or healthcare facility that has provided health care services to me. Additionally, you are hereby authorized to disclose such protected health information to any attorney at law representing such physician, healthcare provider or healthcare facility. Discussion related to my care. You are hereby authorized to discuss my care and treatment with any attorney or representative of an insurance provider if I assert a claim against another physician, health care provider, health care facility or health care entity. This authorization expires in three (3) years after the date of execution shown below. I hereby authorize and direct payment to Guthery Family Practice Clinic LLC for medical benefits under the terms of my insurance. I hereby authorize the release of medical records to the indicated insurance companies) for the purpose of proof of treatment, verification of coverage and pre-certification.

Patient's Rights

I understand I do not have to sign this authorization to receive healthcare benefits (treatment, payment or enrollment) from the person (s) to whom this authorization is directed. I may revoke this authorization in writing at any time. If I do so, it would not affect any actions already taken by someone in reliance on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance coverage. If I wish to revoke this authorization, I shall do so by sending a letter to the person (s) to whom this authorization is directed. Once the health care provider discloses information, any person or organization that receives it may re-disclose it. Patient privacy laws may no longer protect that information. I must sign an authorization form to take part in a research study, or to receive healthcare when the purpose is to create health information for a third party.

____ ______________________________

Patient or legally authorized individual signature **Date**

____ ______________________________

Printed Name (if signed on behalf of patient) **Relationship (parent, guardian, etc.)**

Patient Information

Name:________________________________ DOB:________________________________

E_mail:________________________________ Pharmacy:________________________________

Medical Conditions:____

Allergies:____

Medications:____

Vitals Signs (FOR STAFF USE ONLY)

BP:____________________________ S02:____________________________

Heart Rate:____________________________ Weight:____________________________

RR:____________________________ Height:____________________________

Temperature:____________________________

GEORGIA HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: ____
Name of Healthcare Provider/Physician/Facility/Medicare Contractor

____
Street Address

____
City, State and Zip Code

RE: Patient Name: ______________________________

Date of Birth: ______________ Social Security Number: ______________

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

☐ All physical, occupational and rehab requests, consultations and progress notes.

☐ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.

☐ All employment, personnel or wage records.

☐ All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

☐ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period ____________ to ______________.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human

immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes: ______________________

____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

____

Name of Representative

____

Representative Capacity (e.g. attorney, records requestor, agent, etc.)

____

Street Address

____

City, State and Zip Code

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

____ ______________________

Signature of Patient or Legally Authorized Representative Date
(See 45CFR § 164.508(c)(1)(vi))

____

Name and Relationship of Legally Authorized Representative to Patient
(See 45CFR §164.508(c)(1)(iv))

____ ______________________

Witness Signature Date

Form Made Fillable by eForms

Medical Record Request Form

Name of Medical Practice : ______________________________

Fax Number:______________________________

Patient Name:______________________________

Patient DOB:______________________________

Date Requested:______________________________

Requested by:______________________________

____

Patient Signature

809 W Bankhead Hwy Suite D Villa Rica, GA 30180 Phone: (770) 462-1100 Fax: (770)462-1105